Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	002627	A. BUILDING _____ B. WING _____	C 03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENTWOOD AT HOBART	**1420 ST MARY CIRCLE HOBART, IN 46342**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint number IN00086589. Complaint number IN00086589: Substantiated, No deficiencies related to the allegation are cited. Survey date: March 2, 2011 Facility number: 002627 Provider number: 002627 AIM number: N/A Survey team: Janet Adams, RN Census bed type: Residential: 123 Total: 123 Census payor type; Other: 123 Total: 123 Sample: 7 Brentwood at Hobart was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint number IN00086589. Quality review completed 3-3-11 Cathy Emswiller RN	R 000		